STATE OF CALIFORNIA -- HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

September 12, 1996

ALL COUNTY INFORMATION NOTICE I-48-96

TO: ALL COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[X] Clarification Requested by One or More Counties
[ ] Initiated by CDSS

SUBJECT: REVISED MEDICAL REPORT (CA 61)

The purpose of this notice is to transmit the revised Medical Report, CA 61 (8/96). This form is used to determine incapacity of applicant/recipients for Aid to Families with Dependent Children (AFDC) and Refugees Cash Assistance (RCA). The revised form is reformatted into three major sections making a clear distinction between the area filled out by the applicant/recipient and the area filled out by the licensed physician/certified psychologist. The licensed physician/certified psychologist's instructions section includes a definition of "incapacity" as used by the County Welfare Department. The licensed physician/certified psychologist's statement section is reformatted providing checkboxes and blanks in an effort to facilitate easier usage by the physician/psychologist. See Attachment I for an outline of the specific changes.

STOCK

The Medical Report, CA 61 (8/96) is designated as a required form and substitutes are permitted with prior California Department of Social Services (CDSS) approval. State produced stock of the CA 61 is expected to be available in four to six weeks from the date of this letter.

TRANSLATIONS AND CONTACTS

The CA 61 is formatted to allow for bilingual translation of Section I which is completed by the applicant/recipient. Counties that need a camera-ready copy of the CA 61 should call the Forms Management Unit at (916) 657-1907 or CALNET 437-1907. For camera-ready copies of the Asian language (Chinese, Cambodian, and Vietnamese) versions, counties may either call the Language Services Bureau at (916) 464-1282 or FAX their requests to (916) 657-3429 or CALNET at 473-3429.

If you have questions regarding the CA 61 form, you may contact Donna Morgan of the AFDC Policy Implementation Bureau at (916) 654-5709 or CALNET 464-5709.

Sincerely,

Bruce Wagstaff

BRUCE WAGSTAFF
Deputy Director
Welfare Programs Division

bc: CWDA
Attachment

ATTACHMENT I

Revisions to the Medical Report, CA 61 (8/96):

County Use Only Section includes "Case Name, Worker Name, Case Number and File Number."

The Medical Report form is reformatted into three major sections: **Section I** which is filled out by the patient/applicant/recipient; and **Section II and III** which are aligned in side-by-side columns and pertain to the licensed physician/certified psychologist.

- **Section I** authorizes the release of patient/applicant/recipient's medical information from the licensed physician/certified psychologist to the County Welfare Department (CWD).

- **Section II** outlines the necessity of the form to the licensed physician/certified psychologist, provides a definition of the term "incapacity" as used by the CWD and instructions to the physician/psychologist to help in filling out the form. It also requests return of the form within 5 working days and has space for a return address.

- **Section III** lists 7 questions for physician/psychologists to answer:

  - Item #1 asks the physician/psychologist to indicate by checking the yes or no box if the patient is incapacitated from work. If the answer is yes, further instructions are given to complete items 2 - 7; or, if no, to simply sign and date in the certification section.

  - Item #2 asks the "DIAGNOSIS and PROGNOSIS" for the patient.

  - Item #3 asks the "ONSET DATE FOR THIS INCAPACITY."

  - Item #4 asks the "EXPECTED DURATION OF INCAPACITY," provides two checkboxes to indicate if the incapacity is temporary and the expected date of release, or if it is permanent.

  - Item #5 asks the "DATE OF NEXT SCHEDULED APPOINTMENT."

  - Item #6 asks if the patient's incapacity requires someone to be in the home to care for him/her and provides checkboxes for the answer. This question also includes blanks to explain if the yes box is checked.

  - Item #7 asks for an explanation of how the patient's physical/mental ability is substantially reduced by this incapacity and provides blanks for the answer.

The final section **"Physician or Psychologist Certification"** is to be read and signed by the physician/psychologist. It also requests physician/psychologist's address and phone number.

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

MEDICAL REPORT

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
REFUGEE CASH ASSISTANCE (RCA)

COUNTY USE ONLY	
CASE NAME:	WORKER NAME:
CASE NUMBER	FILE NUMBER:

SECTION I: PATIENT/APPLICANT/RECIPIENT INFORMATION AND MEDICAL RELEASE

NAME OF PATIENT/APPLICANT/RECIPIENT (LAST, FIRST, MIDDLE) *NOMBRE DEL PACIENTE/SOLICITANTE/BENEFICIARIO (APELLIDO, PRIMER NOMBRE, SEGUNDO NOMBRE)*	BIRTHDATE *FECHA DE NACIMIENTO* — —	SOCIAL SECURITY NUMBER *NUMERO DE SEGURO SOCIAL* — —	SEX *(CIRCLE)* *SEXO (PONGA UN CIRCULO)* M F

I authorize _____ of _____
Yo autorizo a (NAME OF LICENSED PHYSICIAN OR CERTIFIED PSYCHOLOGIST) *(NOMBRE DEL DOCTOR CON LICENCIA O PSICOLOGO CERTIFICADO)* *de* (NAME OF CLINIC OR MEDICAL GROUP) *(NOMBRE DE LA CLINICA O GRUPO MEDICO)*
to release my medical information on this form to the County Welfare Department and the California Department of Rehabilitation. This authorization is valid for one year from the date signed and I may ask for a copy of this authorization.
para que proporcione al Departamento de Bienestar Público del Condado y al Departamento de Rehabilitación de California, la información médica que se solicita en esta forma. Esta autorización es válida por un año contado a partir de la fecha de la firma y es posible que yo solicite una copia de esta autorización.

PATIENT/APPLICANT/RECIPIENT SIGNATURE *FIRMA DEL PACIENTE/SOLICITANTE/BENEFICIARIO*	DATE *FECHA*

SECTION II: LICENSED PHYSICIAN OR CERTIFIED PSYCHOLOGIST INSTRUCTIONS

The County Welfare Department needs the following information from you to determine if the above-named person is incapacitated.

"Incapacity" as used by the County Welfare Department means that a physical or mental disability prevents or substantially reduces the patient's ability to engage in full time work, training, or provide necessary care for his/her child(ren).

Please complete the rest of this form. Also explain if the patient needs additional laboratory work or a more complete examination before you can determine the degree and length of incapacity. If you need more space, use another sheet of paper and attach it to this form.

Please give this form to the patient or return it and/or other verification within 5 working days to:

SECTION III: LICENSED PHYSICIAN OR CERTIFIED PSYCHOLOGIST STATEMENT

1. **Is the patient INCAPACITATED from work? ..... ☐ YES ☐ NO**
   (If "YES", complete Items 2 - 7 and Physician/Psychologist Certification. If "NO", sign and date in Certification Section.)
2. **List DIAGNOSIS and PROGNOSIS for this patient:**
   _____
   _____
   _____
   _____
   _____
3. **ONSET DATE FOR THIS INCAPACITY:** _____ (MONTH, DAY, YEAR)
4. **EXPECTED DURATION OF INCAPACITY:**
   ☐ Temporary, expect to release patient from my care _____ (MONTH/YEAR)
   ☐ Permanent
5. **DATE OF NEXT SCHEDULED APPOINTMENT:** _____ (MONTH, DAY, YEAR)
6. **Does patient's incapacity require someone to be in the home to care for him/her? ☐ YES ☐ NO**
   If YES, please explain: _____
   _____
   _____
7. **Explain how patient's physical/mental ability is substantially reduced by this incapacity:** _____
   _____
   _____
   _____
   _____

PHYSICIAN OR PSYCHOLOGIST CERTIFICATION

- I understand that the statements I have made on this form are subject to verification and investigation for welfare fraud.
- I declare under penalty of perjury under the laws of the United States and the State of California that the information contained in this report is true, correct, and complete.

LICENSED PHYSICIAN OR CERTIFIED PSYCHOLOGIST SIGNATURE			DATE	
SPECIALTY			PHONE NUMBER	
STREET ADDRESS	*(MAILING ADDRESS, IF DIFFERENT)*	CITY	STATE	ZIP CODE